

§ 411.20

42 CFR Ch. IV (10–1–07 Edition)

(i) The beneficiary is admitted as an inpatient to a Medicare-participating hospital or CAH, or as a resident to another SNF;

(ii) The beneficiary receives services from a Medicare-participating home health agency under a plan of care;

(iii) The beneficiary receives outpatient services from a Medicare-participating hospital or CAH (but only with respect to those services that are beyond the general scope of SNF comprehensive care plans, as required under § 483.20 of this chapter); or

(iv) The beneficiary is formally discharged (or otherwise departs) from the SNF, unless the beneficiary is readmitted (or returns) to that or another SNF by midnight of the day of departure.

(q) *Assisted suicide.* Any health care service used for the purpose of causing, or assisting to cause, the death of any individual. This does not pertain to the withholding or withdrawing of medical treatment or care, nutrition or hydration or to the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death.

(r) A home health service (including medical supplies described in section 1861(m)(5) of the Act, but excluding durable medical equipment to the extent provided for in such section) as defined in section 1861(m) of the Act furnished to an individual who is under a plan of care of an HHA, unless that HHA has submitted a claim for payment for such services.

(s) Unless § 414.404(d) or § 414.408(e)(2) of this subchapter applies, Medicare does not make payment if an item or service that is included in a competitive bidding program (as described in Part 414, Subpart F of this subchapter) is furnished by a supplier other than a

contract supplier (as defined in § 414.402 of this subchapter).

[54 FR 41734, Oct. 11, 1989; 55 FR 1820, Jan. 19, 1990, as amended at 55 FR 22789, June 4, 1990; 55 FR 31185, Aug. 1, 1990; 57 FR 33897, July 31, 1992; 57 FR 36015, Aug. 12, 1992; 58 FR 30669, May 26, 1993; 59 FR 49834, Sept. 30, 1994; 60 FR 63188, Dec. 8, 1995; 62 FR 46037, Aug. 29, 1997; 62 FR 59101, Oct. 31, 1997; 63 FR 26308, May 12, 1998; 63 FR 35066, June 26, 1998; 64 FR 41682, July 30, 1999; 64 FR 59441, Nov. 2, 1999; 65 FR 18537, Apr. 7, 2000; 65 FR 41211, July 3, 2000; 65 FR 46796, July 31, 2000; 66 FR 32778, June 18, 2001; 66 FR 39600, July 31, 2001; 66 FR 48078, Sept. 17, 2001; 66 FR 55331, Nov. 1, 2001; 66 FR 58786, Nov. 23, 2001; 68 FR 46070, Aug. 4, 2003; 69 FR 66423, Nov. 15, 2004; 70 FR 45055, Aug. 4, 2005; 71 FR 69785, Dec. 1, 2006; 72 FR 18914, Apr. 16, 2007; 72 FR 18084, Apr. 10, 2007]

Subpart B—Insurance Coverage That Limits Medicare Payment: General Provisions

§ 411.20 Basis and scope.

(a) *Statutory basis.* (1) Section 1862(b)(2)(A)(i) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under a group health plan with respect to—

(i) A beneficiary entitled to Medicare on the basis of ESRD during the first 18 months of that entitlement;

(ii) A beneficiary who is age 65 or over, entitled to Medicare on the basis of age, and covered under the plan by virtue of his or her current employment status or the current employment status of a spouse of any age; or

(iii) A beneficiary who is under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of his or her current employment status or the current employment status of a family member.

(2) Section 1862(b)(2)(A)(ii) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under any of the following:

(i) Workers' compensation.

(ii) Liability insurance.

(iii) No-fault insurance.

(b) *Scope.* This subpart sets forth general rules that apply to the types of insurance specified in paragraph (a) of this section. Other general rules that

apply to group health plans are set forth in subpart E of this part.

[60 FR 45361, Aug. 31, 1995, as amended at 71 FR 9470, Feb. 24, 2006]

§ 411.21 Definitions.

In this subpart B and in subparts C through H of this part, unless the context indicates otherwise—

Conditional payment means a Medicare payment for services for which another payer is responsible, made either on the bases set forth in subparts C through H of this part, or because the intermediary or carrier did not know that the other coverage existed.

Coverage or covered services, when used in connection with primary payments, means services for which a primary payer would pay if a proper claim were filed.

Monthly capitation payment means a comprehensive monthly payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient who dialyses at home or as an outpatient in an approved ESRD facility.

Plan means any arrangement, oral or written, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness.

Primary payer means, when used in the context in which Medicare is the secondary payer, any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a primary plan. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans.

Primary payment means, when used in the context in which Medicare is the secondary payer, payment by a primary payer for services that are also covered under Medicare.

Primary plan means, when used in the context in which Medicare is the secondary payer, a group health plan or large group health plan, a workers' compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance.

Prompt or promptly, when used in connection with primary payments, except as provided in § 411.50, for payments by liability insurers, means payment within 120 days after receipt of the claim.

Proper claim means a claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or insurer.

Secondary, when used to characterize Medicare benefits, means that those benefits are payable only to the extent that payment has not been made and cannot reasonably be expected to be made under other coverage that is primary to Medicare.

Secondary payments means payments made for Medicare covered services or portions of services that are not payable under other coverage that is primary to Medicare.

[54 FR 41734, Oct. 11, 1989, as amended at 60 FR 45361, Aug. 31, 1995; 71 FR 9470, Feb. 24, 2006]

§ 411.22 Reimbursement obligations of primary payers and entities that received payment from primary payers.

(a) A primary payer, and an entity that receives payment from a primary payer, must reimburse CMS for any payment if it is demonstrated that the primary payer has or had a responsibility to make payment.

(b) A primary payer's responsibility for payment may be demonstrated by—

(1) A judgment;

(2) A payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary payer or the primary payer's insured; or

(3) By other means, including but not limited to a settlement, award, or contractual obligation.

[71 FR 9470, Feb. 24, 2006]

§ 411.23 Beneficiary's cooperation.

(a) If CMS takes action to recover conditional payments, the beneficiary must cooperate in the action.

(b) If CMS's recovery action is unsuccessful because the beneficiary does not cooperate, CMS may recover from the beneficiary.